



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name

TRANSPORTATION INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-09-5824-01

MFDR Date Received

October 16, 2008

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 15, 2007	Outpatient Hospital Services	\$3,273.09	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
 - 850-243 – CV: THE RECOMMENDED ALLOWANCE REFLECTS A FAIR REASONABLE AND CONSISTENT METHODOLOGY OR REIMBURSEMENT PURSUANT TO THE CRITERIA SET FORTH IN SECTION 413.011(D) OF THE TEXAS WORKERS' COMPENSATION ACT. M-NO MAR. \$0.00
 - M-NO MAR. \$0.00
 - M-NO MAR. \$14.00
 - M-NO MAR. \$15.00
 - M-NO MAR. \$27.00
 - M-NO MAR. \$900.00
 - 900-030 – CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
 - 900-0021 – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 855-013 – PAYMENT DENIED – THE SERVICE IS INCLUDED IN THE GLOBAL VALUE OF ANOTHER BILLED PROCEDURE. \$0.00
 - 44 – Prompt-pay discount.
 - 850-500 – ANY NETWORK REDUCTION IS APPLIED PER AGREEMENT BETWEEN THE PROVIDER AND THE ABOVE REFERENCED NETWORK \$0.00

Findings

1. The insurance carrier denied or reduced payment for disputed services with reason codes 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)"; 900-0021 – "ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE"; 44 – "Prompt-pay discount"; 850-500 – "ANY NETWORK REDUCTION IS APPLIED PER AGREEMENT BETWEEN THE PROVIDER AND THE ABOVE REFERENCED NETWORK \$0.00." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 11, 2011, the Division requested additional information from the respondent pursuant to 28 Texas Administrative Code §133.307(e)(1), which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." The Division requested the respondent to provide a copy of the referenced contract(s) between the alleged network and South Texas Health System; a copy of the contract between Transportation Insurance Company and the alleged network; and documentation to support that the health care provider had been notified that the insurance carrier had been granted access to the alleged contractual fee arrangement between the network and the health care provider. Review of the submitted information finds no documentation to support a contract between the insurance carrier and the health care provider. Review of the submitted contract finds no reference to the health care provider and requestor in this dispute. The respondent did not submit a copy of the contract between the insurance carrier and the alleged network. No information was found to support that the insurance carrier had been granted access to a contractual fee arrangement between the health care provider that applies to the services in dispute. No compelling documentation was found to support that the health care provider had been notified that the insurance carrier had been granted access to any contractual fee arrangement applicable to the services in dispute. The Division therefore concludes that the respondent has failed to support that the disputed services are subject to a contractual fee arrangement. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
1. 28 Texas Administrative Code §133.307(c)(1) states that "A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." According to the requestor's *Table of Disputed Services*, the date of service in dispute is October 15, 2007. The request for medical fee dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 16, 2008. This date is later than one year after the date of service in dispute. October 15, 2008 was not a weekend or holiday. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division has jurisdiction to review this dispute, however, the requestor has waived the right to medical fee dispute resolution by failing to file a timely request for MDR of the disputed services. For that reason, the merits of the fee issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

December 6, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.